

Age Discrimination Act of 1975 (regulations at 45 CFR part 91).

(f) *Requirements for advance directives.* The HMO or CMP must meet all the requirements for advance directives at §417.436(d).

(g) *Authority to waive conflicting contract requirements.* Under section 1876(i)(5) of the Act, CMS is authorized to administer the terms of this subpart without regard to provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if it determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(h) *Collection of fees from risk HMOs and CMPs.* (1) The rules set forth in §422.10 of this chapter for M+C plans also apply to collection of fees from risk HMOs and CMPs.

(2) In applying the part 422 rules, references to “M+C organizations” or “M+C plans” must be read as references to “risk HMOs and CMPs”.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38079, July 15, 1993; 60 FR 45680, Sept. 1, 1995; 63 FR 35067, June 26, 1998]

#### §417.474 Effective date and term of contract.

(a) *Effective date.* The contract must specify its effective date, which may not be earlier than the date it is signed by both CMS and the HMO or CMP.

(b) *Term.* The contract must specify the duration of its term as follows:

(1) For the initial term, at least 12 months, but no more than 23 months.

(2) For any subsequent term, 12 months.

[60 FR 45680, Sept. 1, 1995]

#### §417.476 Waived conditions.

If CMS waives any of the qualifying conditions required under subpart J of this part, the contract must specify the following information for each waived condition:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by CMS.

[60 FR 45680, Sept. 1, 1995]

#### §417.478 Requirements of other laws and regulations.

The contract must provide that the HMO or CMP agrees to comply with—

(a) The requirements for QIO review of services furnished to Medicare enrollees as set forth in subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect enrollees of the HMO or CMP; and

(d) The reporting requirements in §417.126(a), which pertain to the monitoring of an HMO's or CMP's continued compliance.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, 38082, July 15, 1993]

#### §417.479 Requirements for physician incentive plans.

(a) The contract must specify that an HMO or CMP may operate a physician incentive plan only if—

(1) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

(2) The stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

(b) *Applicability.* The requirements in this section apply to physician incentive plans between HMOs and CMP and individual physicians or physician groups with which they contract to provide medical services to enrollees. The requirements in this section also apply to subcontracting arrangements as specified in §417.479(i). These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicare beneficiaries or Medicaid recipients.

(c) *Definitions.* For purposes of this section:

*Bonus* means a payment an HMO or CMP makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.